MEDICAL HISTORY: SPORT VISITOR PROGRAMS

Name *(family, first, middle)*
_____
_____Male _____Female
Birth Date (mm/dd/yyyy) _____
Mailing address
_____
_____
_____
_____
_____
Telephone_____

DATE OF IMMUNIZATIONS

(These shots are the minimum required.)
Mumps
_____
Diphtheria/Tetanus *(required within ten years)*
_____
Measles *(first date)*
_____
Measles *(second date)*
_____
Polio
_____
Rubella (German measles)
_____
Other
_____

PERSONAL HISTORY

Please check if you have had:

- □ Tuberculosis
- □ Scarlet Fever
- □ Measles
- □ Rubella (German Measles)
- □ Chicken Pox
- □ Rheumatic fever
- □ Hepatitis
- □ Malaria
- □ Polio
- □ Other _____

Surgery

- □ Appendectomy
- □ Tonsillectomy
- □ Hernia Repair
- □ Other _____

Allergy (Please specify.)

- □ Eczema
- □ Asthma
- □ Hay Fever
- □ Foods
- □ Other_____

Habits (How much/How often)

- □ Alcohol _____
- □ Tobacco_____
- □ Other _____

FAMILY HISTORY

Age & State of health
Father _____
Mother _____
Brothers _____
Sisters _____

Have any immediate family members had:
Tuberculosis _____
Asthma _____
Diabetes _____
Cancer _____
Heart disease _____
Epilepsy/convulsions _____
Other_____

REVIEW OF PAST ILLNESSES AND SYMPTOMS

Please complete the following, adding additional paper if necessary.

A. Has your physical activity been restricted during the past five years? (Give reasons and duration.)
_____
_____
_____
_____

B. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years (other than routine check-ups)?
(Give details.)
_____
_____
_____
_____

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C. In the last five years, have you consulted or been treated by a psychiatrist, clinical psychologist, drug/alcohol counselor, or other mental health professional? If yes, explain here, and have your counselor or physician complete Part III.

_____
_____
_____
_____

D. List any hospitalizations with diagnosis and date.

_____
_____
_____
_____

E. Have you ever had a serious acute illness? (Give details.)

_____
_____
_____
_____

F. Do you have any chronic/recurrent illness? Any permanent/chronic injury or physical disability? (Give details.)

_____
_____
_____
_____

G. Have you had any allergic reaction to prescription or over-the-counter medicines? (Give details.)

_____
_____
_____
_____

H. Have you had any allergic reaction to past immunizations? (Explain.)

_____
_____
_____
_____

I. Are you currently taking any medications (including oral contraceptives)? (List and give details.)

_____
_____
_____
_____

J. Are you currently receiving antigen/immunotherapy injections or prescription medication for an allergy? (List.)

_____
_____
_____
_____

K. Do you have any health requirements or dietary restriction based upon religion? (Explain.)

_____
_____
_____
_____

L. Do you have any habits which might adversely affect your health?

_____
_____
_____
_____

Please check if you have had:

- □ Unexplained fever
- □ Immune system problems
- □ Stomach ulcer
- □ Epilepsy (seizures)
- □ Recent weight gain or loss
- □ Heart murmur
- □ Gall bladder trouble
- □ Recurrent dizziness or faintness
- □ Eye trouble
- □ Heart palpitations
- □ Hernia (rupture)
- □ Depression
- □ Hearing loss
- □ Chest pain, pressure
- □ Kidney stone
- □ Severe headaches
- □ Sinus problems
- □ Chronic cough
- □ Albumin or blood in urine
- □ Chronic rash

MEDICAL HISTORY: SPORT VISITOR PROGRAMS

- □ Shortness of breath, wheezing
- □ Painful/swollen joint
- □ Anemia
- □ Abdominal pain
- □ "Trick Knee" or other joint
- □ Chronic diarrhea
- □ Bleeding/clotting problems
- □ Chronic indigestion
- □ Back problems
- □ Impaired use of any limbs
- □ Cancer or leukemia

Women only

- □ Irregular periods
- □ Cramps
- □ Excessive flow

Comment below on any condition(s) above which you have checked.

_____
_____
_____
_____
_____
_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND PERMISSION FOR EMERGENCY MEDICAL TREATMENT

Please complete and sign the following:

We *(applicant, legal guardian if under 18)*

_____
_____

Hereby authorize *(name of physician)*

_____

To release any and all medical records or information pertaining to the applicant to the Department of State Cooperating Agency. We also authorize the release of such information to the parent or legal guardian or designated contact person in the event of an emergency.

We hereby consent to the administration of routine medical treatment to the applicant via the physicians and health care professionals.

On rare occasions, an emergency requiring treatment in a hospital and/or surgery may develop. In most cases, administration of an anesthetic, treatment of an injury, or operation cannot be done without the consent of the patient, and if the patient is under 18, without the consent of a custodial parent or legal guardian. In order to prevent a dangerous delay in an emergency situation where AED is either unable to contact a parent or guardian, or if the applicant is unconscious or otherwise unable to give consent, we hereby authorize AED's representative to secure whatever medical treatment is deemed necessary, including administration of an anesthetic and surgery.

We hereby verify that all of the information contained in this form is accurate and acknowledge that any failure to provide accurate information may result in the applicant's dismissal from the program. We agree to notify AED of any material changes in the applicant's health that may occur prior to the start of the program.

Signature of applicant

_____

Date *(mm/dd/yyyy)* _____

Signature of custodial parent or legal guardian *(if applicant is under 18)*

_____

Date *(mm/dd/yyyy)* _____

Person to contact in an emergency

_____

Telephone _____

Relationship to applicant _____

Program name

_____

Start date *(mm/dd/yyyy)* _____